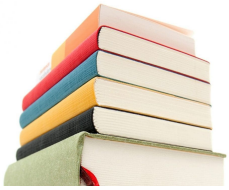

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What's in the Longest Bill Congress Has Ever Passed? Employee Benefits Provisions in the Consolidated Appropriations Act

At 5,593 pages, the Consolidated Appropriations Act, 2021 ("Act") is the longest bill ever passed by Congress. The Act was signed into law by President Trump on December 27, 2020. As you can imagine, the Act contains a variety of provisions, including a $1.4 trillion appropriations package to fund the government through September 30, 2021 and a long-awaited COVID-19 relief package in the amount of $900 billion. This update will focus on the COVID-19 relief package, and specifically the provisions affecting employee benefit plans. The first section of this update outlines the main provisions affecting health and welfare plans, while the second section addresses retirement plans.

Health and Welfare Plan Provisions

Flexible Spending Accounts

When the pandemic began, the IRS issued special rules for Flexible Spending Account (FSA) plans to expand the ability of participants to make mid-year contribution changes and to relax the use-it-or-lose-it rules. Plan sponsors can choose whether to allow participants to take advantage of this relief. Plan amendments are required if these new favorable provisions are implemented for FSAs. The Act extends and expands the relief for FSAs, as follows:

Carryovers. Both health and dependent care FSAs may allow participants to carry over unused amounts in a participant's account from 2020 to 2021 and from 2021 to 2022, without limit.

Grace Period Extension. Both types of FSAs may extend a grace period for a plan year ending in 2020 or 2021 to 12 months after the end of the plan year, so unused amounts in the FSA may be used during such extended grace period.

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Health FSA Reimbursements. Health FSAs may allow employees who cease participation in the plan during 2020 or 2021 to continue to spend down account balances through the end of the plan year in which the employee ceases participation, plus any grace period. Employers will need to decide whether to implement this rule for active employees or for terminated employees as well, and how COBRA will interact with any changes.

Dependent Care FSA Age Out. The normal rule is that a dependent care FSA can be used for expenses related to children under 13. Dependent care FSAs may be amended to allow participants who have a qualifying child turning age 13 during a plan year with a regular enrollment period on or before January 31, 2020 to continue to receive reimbursements for the child's dependent care expenses for the remainder of the plan year and, with respect to any remaining balance, the next plan year, until the child turns 14.

Election Changes. Both types of FSA may allow prospective election changes for a plan year ending in 2021, without regard to whether a permitted election change event occurred. This extends guidance issued last year in IRS Notice 2020-29 that allowed participants to make election changes on a going-forward basis if the plan implemented the new special rule.

Student Loan Repayments

The Act extends the CARES Act provision allowing employer payment of qualified student loan payments of employees on a tax-free basis, up to $5,250, to January 1, 2026. See our prior update addressing the original employee student loan payments deadline.

Transparency Provisions

Removing Gag Clauses. The Act amends the Public Health Service Act (PHSA), the Internal Revenue Code ("Code"), and the Employee Retirement Income Security Act (ERISA) to provide that group health plans and issuers cannot enter into agreements with providers, a network or association of providers, third-party administrators, or other service providers offering access to a network of providers that would directly or indirectly restrict the

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plan from (i) disclosing provider-specific cost and quality information, (ii) electronically accessing de-identified claim information, or (iii) sharing the above information, or directing that it be shared, with a business associate, consistent with the Health Insurance Portability and Accountability Act (HIPAA) privacy rules, Genetic Information Nondiscrimination Act (GINA), and the *Americans with Disabilities Act* (*ADA*) . Plans will be required to submit an annual attestation to the DOL that they comply with this rule. This provision is effective immediately and will possibly require agreements with Third Party Administrators (TPA) to be immediately amended.

Disclosure of Broker Compensation. The Act amends Section 408(b)(2) of ERISA to require brokers and consultants to group health plans to disclose at the time of contracting any direct or indirect compensation that will be received as a result of the services provided to the plan in excess of $1,000. This becomes effective December 28, 2021, one year from the Act's date of enactment.

Mental Health Parity. The ***PHSA***, Code, and ERISA have been amended by the Act to require group health plans and health insurance issuers subject to the Mental Health Parity and Addiction Equity Act (MHPAEA) to formally analyze and document compliance with the MHPAEA within 45 days after the date of enactment of the Act. Plans and issuers are required to implement a comparative analysis of the nonquantitative treatment limitations used for medical and surgical benefits and mental health and substance abuse benefits. The law requires plans and issuers to make the compliance analysis available to the Department of Labor (DOL)or the Department of Health and Human Services (HHS) upon request and requires the DOL and HHS to conduct at least 20 reviews of plan or issuer analyses each year.

The IRS, DOL, and HHS are to issue a compliance program guidance document to assist plans and issuers in complying with the new requirement within 18 months of enactment of the Act. The regulators are also required to provide clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that plans may use regarding the

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development and application of nonquantitative treatment limitations. Employers with self-insured plans should begin communicating with TPAs now about coordinating compliance with this requirement.

Pharmacy Reporting. The Act requires group health plans and health insurance issuers to submit to the IRS, DOL, and HHS detailed information related to prescription drug coverage, including the 50 brand prescription drugs most frequently dispensed by pharmacies and paid by the plan, the 50 most costly prescription drugs by total annual spending, the 50 prescription drugs with the greatest increase in plan expenditures over the prior plan year, enrollee premiums, and any manufacturer rebates received by the plan or issuer, including the rebate's impact on premiums, if any. The first submission to the regulators must be made within one year of the enactment of the Act and then annually as of each June 1 thereafter. Employers with self-insured plans should begin communicating with TPAs now about coordinating compliance with this requirement.

No Surprises Act

Title I of Division BB of the Act, titled the "No Surprises Act" amends the PHSA, Code, and ERISA to address surprise billing where patients have little or no control over who provides their care, to impose disclosure requirements giving participants advance medical cost information, and dispute resolution requirements. The No Surprises Act is generally effective for plan years beginning on or after January 1, 2022. If an employer-provided medical plan is fully insured, the insurer will be responsible for compliance. But most medium to large employers have self-funded major medical. For self-funded plans, the TPA is in the best position to implement these new requirements and they will likely do so, but the employer is ultimately responsible for compliance and potentially subject to penalties. All self-funded employers should be sure their administrative service agreements are amended in 2021 to require the TPA to provide these compliance services.

These provisions apply to group health plans and health insurance issuers and address what rates the plan or issuer must use for out-of-network providers at in-network facilities, emergency services

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provided at out-of-network facilities or by out-of-network providers, and air ambulance services.

Plans that cover emergency services must cover out-of-network emergency services at in-network cost-sharing, without prior authorization. Any medical services provided at in-network facilities by out-of-network providers must be covered with in-network cost-sharing, and out-of-network air ambulance services must also be covered using in-network cost-sharing if the plan covers in-network air ambulance services.

For non-emergency services provided at in-network facilities by out-of-network providers, the out of network provider can only balance bill the participant if the participant consents and has received notice of the charges 72 hours prior to receiving the service; however, such consent is not allowed to be requested if (i) there is no in-network provider available at the facility, (ii) the care is for unforeseen or urgent services, or (iii) the provider is an ancillary provider that a patient does not usually select (e.g., radiologist, anesthesiologist, pathologist, etc.). Where consent cannot be requested, the participant cannot be charged more than the participant would pay if the provider was in-network. Regulations implementing the methodology for making payments must be finalized by July 1, 2021.

Additional provisions of the No Surprises Act are summarized below:

Prompt Payment/Dispute Resolution. Plans must send either an initial payment or a notice of denial to a provider within 30 days of receiving a bill. The parties then have 30 days to initiate open negotiations, which can last for up to 30 days. If an agreement cannot be reached within the 30 day period, either party has four days to notify the other and HHS of intent to initiate a new, required Independent Dispute Resolution process.

Insurance ID Cards. Plan deductibles, out-of-pocket limits, and consumer assistance information must be clearly printed on all insurance ID cards.

External Review. The external review process enacted as part of the Affordable Care Act will apply to any adverse benefit determination under the surprise billing provisions.

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EOB Estimates. In connection with the next item, an advanced explanation of benefits must be provided containing good faith estimates of the costs of services the individual is scheduled to receive.

Patient/Provider Dispute Resolution. Providers must give individuals good faith estimates of expected charges for scheduled services within certain timeframes. A dispute resolution process will be implemented by HHS for uninsured individuals in cases where actual charges substantially exceed estimated charges.

Continuity of Care. Individuals undergoing treatment for serious or complex conditions, who are pregnant, receiving inpatient care, are scheduled for non-elective surgery, or who are terminally ill must receive 90 days of continued in-network care from a plan or issuer if a provider leaves a network.

Price Comparison Tool. Plans must maintain a price comparison tool available via telephone or online that allows enrolled individuals and participating providers to compare cost sharing for items and services.

Loss of Network Provider Status. Plans must verify and update provider directories at least every 90 days and establish a system to respond to individuals within one business day regarding the network status of a provider.

Defined Contribution Retirement Plan Provisions

Temporary Partial Plan Termination Safe Harbor

Under the Act, employers who restore jobs by March 2021 may not have experienced a partial termination of their 401(k) or other retirement plans under the partial plan termination rules.

As we noted in our earlier client update, if the number of participants in a retirement plan drops significantly, the plan can be required to vest all impacted participants. This "partial termination" rule is only a concern for plans that have a vesting schedule. We are seeing an increasing number of plans that have 100% immediate vesting in employer contributions either because contributions are

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safe-harbor and required to be vested when contributed, or because the employer wants to simplify plan administration and the potential costly errors that can occur with counting vesting service.

For plans with a vesting schedule, the tax rules require 100% immediate vesting of the accounts of participants who terminated during the applicable period if a partial plan termination has occurred. The applicable period is typically a single plan year but can span multiple plan years if the termination events are related. Under IRS regulations, whether a partial plan termination has occurred is based on all the facts and circumstances, but the IRS presumes a partial plan termination has occurred if the turnover rate is higher than 20%. The presumption is rebuttable based on extenuating facts and circumstances.

Under the new rule in the Act, a retirement plan will not be treated as having experienced a partial plan termination during any plan year that includes the period of March 13, 2020 through March 31, 2021, if the number of active participants covered by the plan on March 31, 2021 is at least 80% of the number of active participants covered by the plan on March 13, 2020. This temporary relief may be helpful to plan sponsors who had to lay off or furlough a substantial number of employees in 2020 due to COVID-19, but who have or will hire a number of former or new employees by March 31, 2021.

Disaster Distribution and Loan Rules

Similar to special rules for prior natural disasters and for COVID-19, the new rules allow those who principally resided in a qualified disaster area at any time during the incident period (as reported by the Federal Emergency Management Agency (FEMA), and who sustained an economic loss due to the disaster, to take loans and distributions (which can be re-contributed) from 401(k) and other defined contribution plans or to suspend loan payments on new or existing plan loans that otherwise would not be permitted. A qualified disaster is defined as any area declared a major disaster by the president between January 1, 2020 and February 25, 2021 (60 days after the Act's enactment), such as the California wildfires and record-breaking hurricanes and tropical storms in 2020, as

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long as the disaster occurred between December 28, 2019 and December 27, 2020. This relief does not apply to areas where a disaster was declared only due to COVID-19, but rules issued earlier provide essentially the same relief for the COVID-19 emergency.

Disaster Distributions. A participant can take a distribution from a defined contribution plan (including an IRA) of up to $100,000 for each qualified disaster that has affected the participant. The early withdrawal 10% penalty does not apply to the distribution, and the participant may take the distribution into income ratably over a three-year period or re-contribute the amount to an eligible retirement plan within three years of taking the distribution. The distribution must be made on or after the first day of the disaster's incident period (as declared by FEMA) but before June 25, 2021.

Increase in Plan Loan Limits and Extension of Repayment Period. For loans taken on December 27, 2020 through June 25, 2021, the amount of defined contribution plan loans that can be taken is the lesser of $100,000 or 100% of the participant's vested balance instead of the normal limit of the lesser of $50,000 or 50% of the participant's vested balance.
In addition, repayments for loans that were outstanding on or after the first day of the disaster's incident period, and have a repayment due date that occurs during the period that begins on the first day of the incident period and ends on the day that is 180 days after the last day of the incident period, may be extended by one year (or if later, until June 25, 2021). The one-year extension is disregarded for purposes of the maximum loan repayment term, and the loan is reamortized to reflect the extension and the interest accrued during the suspension.

Repayment of Hardship Withdrawals. Under the Act, a participant who took a hardship withdrawal from a defined contribution plan to purchase or construct a principal residence may recontribute the amount to an eligible retirement plan if the distribution could not be used due to the occurrence of the disaster in the home's location. The participant must have received the withdrawal during the period beginning on the date that is 180 days before the first day of the incident period (as declared by FEMA) and ending on the date that is 30 days after the end of the incident period. The amount

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may be contributed to an eligible retirement plan during the period that begins on the first day of the incident period of the disaster and before June 25, 2021.

Coronavirus-related Distributions (CRDs) and Money Purchase Plans

The CARES Act, passed in March of 2020, allowed qualifying individuals to take up to $100,000 in CRDs from qualified retirement plans in 2020. The Act amended the CARES Act to clarify that in-service distributions taken from a Money Purchase Pension Plan (MPP) or from MPP assets can be classified as CRDs. The amendment applies retroactively to the passage of the CARES Act, but the CRD must have been taken by December 31, 2020, so this change will be of limited value to most plan sponsors.

For more information, please contact Carl Lammers, Kellie Money or any attorney with Frost Brown Todd's Employee Benefits & ERISA Practice Group.

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